		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045617

Facility Name: Lawrence Community Healthcare Center

Address: 900 E. Corporation Street (Number) Bridgeport (City) 62417 (Zip Code)

County: Lawrence

Telephone Number: (618) 945-2091 **Fax #** (618) 945-9030

IDPA ID Number: 42101

Date of Initial License for Current Owners: 08/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: John Knoblett **Telephone Number:** (618) 943-3344

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) William R. Gillis
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) John Knoblett, Member
(Firm Name & Address) Kemper CPA Group LLP, 1100 Lexington Ave., Lawrenceville, IL 62439
(Telephone) (618) 943-3344 Fax # (618) 943-2368

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,789	9,978	3,302	25,069	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,789	9,978	3,302	25,069	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.38%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 3,302

Medicare Intermediary Administar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	145,279	14,696	4,952	164,927		164,927	(7,547)	157,380			1
2	Food Purchase		137,868		137,868		137,868	(272)	137,596			2
3	Housekeeping	122,016	22,955		144,971		144,971		144,971			3
4	Laundry	35,507	33,111	911	69,529		69,529		69,529			4
5	Heat and Other Utilities			51,666	51,666		51,666		51,666			5
6	Maintenance	21,554	3,799	65,355	90,708		90,708		90,708			6
7	Other (specify):*											7
8	**TOTAL General Services**	324,356	212,429	122,884	659,669		659,669	(7,819)	651,850			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	838,644	40,717	22,389	901,750	(204,540)	697,210	(3,760)	693,450			10
10a	Therapy			299,042	299,042	(2,973)	296,069		296,069			10a
11	Activities	40,808	2,235	1,479	44,522		44,522		44,522			11
12	Social Services	27,934		1,480	29,414		29,414		29,414			12
13	Nurse Aide Training											13
14	Program Transportation			165	165		165		165			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	907,386	42,952	326,755	1,277,093	(207,513)	1,069,580	(3,760)	1,065,820			16
	C. General Administration											
17	Administrative	78,564		230,499	309,063	(87,842)	221,221	(34,363)	186,858			17
18	Directors Fees											18
19	Professional Services			14,710	14,710	2,482	17,192		17,192			19
20	Dues, Fees, Subscriptions & Promotions			12,230	12,230		12,230		12,230			20
21	Clerical & General Office Expenses	47,651		64,862	112,513	47,689	160,202	(20,096)	140,106			21
22	Employee Benefits & Payroll Taxes			154,688	154,688	21,469	176,157		176,157			22
23	Inservice Training & Education			3,290	3,290		3,290		3,290			23
24	Travel and Seminar			10,633	10,633	4,608	15,241		15,241			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,073	64,073	794	64,867		64,867			26
27	Other (specify):*											27
28	**TOTAL General Administration**	126,215		554,985	681,200	(10,800)	670,400	(54,459)	615,941			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,357,957	255,381	1,004,624	2,617,962	(218,313)	2,399,649	(66,038)	2,333,611			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lawrence Community Healthcare Center #0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,075	73,075	29,466	102,541		102,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					61,281	61,281	(1,369)	59,912			32
33	Real Estate Taxes			24,826	24,826		24,826		24,826			33
34	Rent-Facility & Grounds			145,493	145,493	(90,232)	55,261	(55,261)				34
35	Rent-Equipment & Vehicles					9,116	9,116		9,116			35
36	Other (specify):*											36
37	**TOTAL Ownership**			243,394	243,394	9,631	253,025	(56,630)	196,395			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			159,521	159,521	207,513	367,034		367,034			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,797	54,797		54,797		54,797			42
43	Other (specify):* See schedule Pg 24			230	230	1,169	1,399	(1,399)				43
44	**TOTAL Special Cost Centers**			214,548	214,548	208,682	423,230	(1,399)	421,831			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,357,957	255,381	1,462,566	3,075,904		3,075,904	(124,067)	2,951,837			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (3,760)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,547)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,369)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(272)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,608)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,399)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,150)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,699)	17		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,338)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,142)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(79,925)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (79,925)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (124,067)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lawrence Community Healthcare Center

ID# 0045617

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending machine	$ (1,140)	21	1
2	Miscellaneous	(198)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,338)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(7,547)	0	0	0	0	0	0	0	0	0	0	(7,547)	1
2	Food Purchase	(272)	0	0	0	0	0	0	0	0	0	0	(272)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,819)	0	0	0	0	0	0	0	0	0	0	(7,819)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,760)	0	0	0	0	0	0	0	0	0	0	(3,760)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,760)	0	0	0	0	0	0	0	0	0	0	(3,760)	16
	C. General Administration													
17	Administrative	(9,699)	(24,664)	0	0	0	0	0	0	0	0	0	(34,363)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(20,096)	0	0	0	0	0	0	0	0	0	0	(20,096)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,795)	(24,664)	0	0	0	0	0	0	0	0	0	(54,459)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,374)	(24,664)	0	0	0	0	0	0	0	0	0	(66,038)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0045617 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,369)	0	0	0	0	0	0	0	0	0	0	(1,369)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(55,261)	0	0	0	0	0	0	0	0	0	(55,261)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,369)	(55,261)	0	0	0	0	0	0	0	0	0	(56,630)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	43
44	**TOTAL Special Cost Centers**	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,142)	(79,925)	0	0	0	0	0	0	0	0	0	(124,067)	45

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
William J. Rincker Trust	100%	West Grove, Inc.	Lawrenceville, IL			
William J. Rincker Trust	100%	Friendship Manor	St. Elmo, IL			
William J. Rincker Trust	80%	Lawrence Community Healthcare	Bridgeport, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 220,800	Rincker Healthcare, Inc.	100.00%	$ 196,136	$ (24,664)	1
2	V	34	Facility Rental	145,493	William J. Rincker Trust	100.00%	90,232	(55,261)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 366,293			$ 286,368	$ * (79,925)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	William Rincker	Administrator	Management	80.00	162,273	15.4	38.55	Wages	$ 98,218	17-1	1
2	Jane Rincker	Accounting Supr.	Bookkeeping		52,294	15.4	38.55	Wages	31,652	21-1	2
3	William Rob Gillis	Administrator	Management	20.00		40	100.00	Wages	77,987	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 207,857		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rincker Healthcare, Inc.
Street Address: 1211 Gulf of Mexico Drive, Unit 811
City / State / Zip Code: Longboat Key, FL 34228
Phone Number: (941) 383-0351
Fax Number: (941) 383-0481

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See attached schedule pg. 25				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Community Bank & Trust		X	Purchase	$8,437.77	08/02/96	$ 1,014,000	$ 895,387	09/15/17	6.5000	$ 60,197	1
2				Amortization of loan costs							569	2
3	Community Bank & Trust		X	Purchase-Rincker Healthcare							515	3
4				see pg 25								4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$8,437.77		$ 1,014,000	$ 895,387			$ 61,281	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,014,000	$ 895,387			$ 61,281	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0045617 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	21,942	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	23,384	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,442	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	23,384	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	24,826	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	12,417	8
	1999	12,357	9
	2000	21,588	10
	2001	21,942	11
	2002	23,384	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lawrence Community Healthcare Center COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0045617

CONTACT PERSON REGARDING THIS REPORT John Knoblett

TELEPHONE (618) 943-3344 FAX #: (618) 943-2368

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-000-701-0A	Land and Building	$ 23,384.04	$ 23,384.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,384.04	$ 23,384.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	52,541		$ 20,500	1
2					2
3	TOTALS	52,541		$ 20,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1996		$ 664,000	$ 16,600	40	$ 16,600	$	$ 124,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Siding			1997	5,300	133	40	133		861	9
10	Two four ton air conditioning units			1997	3,586	359	10	359		2,331	10
11	Fire alarm system			1998	17,000	1,133	15	1,133		6,800	11
12	Telephone system w/ call lights			1998	17,300	1,730	10	1,730		9,371	12
13	Concrete pads			1998	734	49	15	49		261	13
14	Awning at back door			1998	890	59	15	59		316	14
15	Wallpaper/ painting			1998	2,444	367	5	367		2,444	15
16	Asphalt parking lot			1998	13,374	1,337	10	1,337		7,690	16
17	Landscaping / trees / shrubs			1998	2,906	291	10	291		1,622	17
18	Parking lot			1999	1,029	103	10	103		437	18
19	Flooring / tiling			1999	12,600	1,260	10	1,260		6,195	19
20	Carpentry work			1999	3,645	243	15	243		1,175	20
21	Bathroom renovation			1999	3,570	238	15	238		1,131	21
22	Hot water system			1999	10,500	700	15	700		3,325	22
23	Hand rails			1999	3,520	235	15	235		1,115	23
24	Wallpaper/ painting			1999	3,142	628	5	628		2,933	24
25	Alarm system			2000	5,297	353	15	353		1,618	25
26	Replacement Windows			2000	3,864	258	15	258		987	26
27	Water heater			2000	4,350	435	10	435		1,631	27
28	Flooring / tiling			2000	3,200	320	10	320		1,173	28
29	Plumbing			2000	1,719	86	20	86		308	29
30	Fire suppression system			2000	1,849	74	25	74		253	30
31	Flooring / tiling			2000	2,600	260	10	260		888	31
32	Flooring / tiling			2001	4,450	445	10	445		1,335	32
33	Flooring / tiling			2001	3,340	334	10	334		974	33
34	Flooring / tiling			2001	3,150	315	10	315		919	34
35	Flooring / tiling			2001	4,450	445	10	445		1,298	35
36	Flooring / tiling			2001	2,625	263	10	263		766	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	B-fold doors	2001	$ 1,665	$ 166	10	$ 166	$	$ 458	37
38	120 gal water heater	2001	2,483	248	10	248		538	38
39	Water heater	2002	2,961	296	10	296		568	39
40	Temperature control valve	2002	980	98	10	98		188	40
41	Chandeliers	2002	1,532	153	10	153		281	41
42	Windows	2002	1,900	190	10	190		238	42
43	Carpet	2003	3,378	141	10	141		141	43
44	Carpet	2003	1,570	26	10	26		26	44
45	Water softener	2003	2,103	18	10	18		18	45
46	Air conditioning Units	2003	77,655	3,236	10	3,236		3,236	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 902,661	$ 33,625		$ 33,625	$	$ 190,349	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 534,846	$ 54,283	$ 54,283	$	5-10	$ 389,944	71
72	Current Year Purchases	3,627	121	121		10	121	72
73	Fully Depreciated Assets	3,043				5	3,043	73
74								74
75	TOTALS	$ 541,516	$ 54,404	$ 54,404	$		$ 393,108	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport patients	2000 Ford E-250HD Van	1999	$ 36,009	$ 7,502	$ 7,502	$	4	$ 36,009	76
77	Transport patients	2001 Chrysler T & C Van	2001	35,051	7,010	7,010		5	20,447	77
78										78
79										79
80	TOTALS			$ 71,060	$ 14,512	$ 14,512	$		$ 56,456	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,535,737	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 102,541	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 102,541	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 639,913	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	2340.75 hrs	$ 111,952		$	$	2,341	$ 111,952	1
2	Licensed Speech and Language Development Therapist	10A-3	1104.25 hrs	53,267				1,104	53,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	2985 hrs	126,449				2,985	126,449	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	38								12
13	Other (specify):									13
14	TOTAL			$ 291,668		$	$	6,430	$ 291,668	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 365,670	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	452,494		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,059		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 827,223	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	88,406		15
16	Equipment, at Historical Cost	616,250		16
17	Accumulated Depreciation (book methods)	(454,258)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 250,398	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,077,621	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 150,393	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,172		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,017		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,384		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Ins/Wage Garnishment	(646)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 231,380	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Owner Advances	518,713		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 518,713	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 750,093	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 327,528	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,077,621	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 26,656	1
2	Restatements (describe):		2
3	**Voided old outstanding checks**	14,563	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 41,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	657,559	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(371,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 286,309	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 327,528	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,555,636	1
2	Discounts and Allowances for all Levels	(659,102)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,896,534	3
	B. Ancillary Revenue		
4	Day Care	3,760	4
5	Other Care for Outpatients		5
6	Therapy	518,486	6
7	Oxygen	42,156	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 564,402	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,140	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,547	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	175,198	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,523	19
20	Radiology and X-Ray	4,786	20
21	Other Medical Services	33,765	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 270,959	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,369	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,369	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	199	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 199	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,733,463	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	659,669	31
32	Health Care	1,277,093	32
33	General Administration	681,200	33
	B. Capital Expense		
34	Ownership	243,394	34
	C. Ancillary Expense		
35	Special Cost Centers	159,521	35
36	Provider Participation Fee	54,797	36
	D. Other Expenses (specify):		
37	Contributions	230	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,075,904	40
41	**Income before Income Taxes (line 30 minus line 40)****	657,559	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 657,559	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,012	2,012	$ 48,552	$ 24.13	1
2	Assistant Director of Nursing	2,080	2,080	37,586	18.07	2
3	Registered Nurses	8,084	8,384	152,572	18.20	3
4	Licensed Practical Nurses	10,554	11,094	175,777	15.84	4
5	Nurse Aides & Orderlies	48,658	50,580	408,687	8.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,272	2,392	20,717	8.66	9
10	Activity Assistants	2,979	2,994	20,091	6.71	10
11	Social Service Workers	2,551	2,673	27,934	10.45	11
12	Dietician					12
13	Food Service Supervisor	1,875	1,995	25,281	12.67	13
14	Head Cook	6,759	7,017	49,774	7.09	14
15	Cook Helpers/Assistants	6,808	7,221	57,468	7.96	15
16	Dishwashers	1,955	1,955	12,756	6.52	16
17	Maintenance Workers	1,916	2,004	21,554	10.76	17
18	Housekeepers	15,797	16,100	122,016	7.58	18
19	Laundry	4,600	4,885	35,507	7.27	19
20	Administrator	2,012	2,012	78,564	39.05	20
21	Assistant Administrator	1,175	1,199	21,632	18.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,125	2,397	26,019	10.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,741	1,861	15,470	8.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,953	130,855	$ 1,357,957 *	$ 10.38	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	167	$ 4,952	01-03	35
36	Medical Director	48	2,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	584	39-03	39
40	Physical Therapy Consultant	123	5,437	10A-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,479	11-03	44
45	Social Service Consultant	37	1,479	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	436	$ 16,131		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Rob Gillis	Administrator	20%	$ 78,564
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,564

B. Administrative - Other

Description	Amount
Management fees	$ 220,800
Replacement tax	9,699
TOTAL (agree to Schedule V, line 17, col. 3)	$ 230,499
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kemper CPA Group	Accounting	$ 14,660
James Stout	Legal	50
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,710

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,966
Unemployment Compensation Insurance	10,452
FICA Taxes	109,128
Employee Health Insurance	24,957
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	654
TOTAL (agree to Schedule V, line 22, col.8)	$ 176,157

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 378
Advertising: Employee Recruitment	9,968
Health Care Worker Background Check	
(Indicate # of checks performed 54)	658
Dues & Subscriptions	1,226
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,230

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel from home office	2,864
In-State Travel	
Program transportation - oil & gas	8,976
Seminar Expense	3,401
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,241

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center # 0045617 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0045617 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,797**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Adjustments, line 29	Amount	Line
Vending machine revenue	(1,140.00)	21
Miscellaneous income	(198.00)	21
	(1,338.00)	

Page 4, line 43 detail

	Column 3	Column 5	Total
Contributions	230	1,169	1,399
			1,399

Pg 15

There are no training fees because Lawrence Community only hires fully-trained employees.

Pg 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

Line Description	Amount	Line Ref
Administrative	108,294	17
Professional Services	2,482	19
Clerical & General Office Expenses	47,689	21
Employee Benefits & Payroll Taxes	21,469	22
Travel and Seminar	4,608	24
Insurance - Prop.Liab.Malpractice	794	26
Interest	515	32
Rent - Equipment & Vehicles	9,116	35
Donations	1,169	43
Administrative	196,136	17
Depreciation	29,466	30
Interest	60,766	32
Rent - Facility Grounds	90,232	34
Grand Total of allocated costs	286,368	

Reconciliation of taxable income to book net income

Book Net income	657,559
Prior period adjustment	14,563
Difference book vs. tax depreciation	(50,607)
Disallowed Meals & Entertainment	1,432
Accrual to cash conversion	13,266
Taxable Income	636,213

Breakdown of owner salaries from other nursing homes

	William Rincker	Jane Rincker
Friendship Manor	59,785.00	19,266.00
West Grove	56,582.00	18,234.00
Lawrence Comm. Healthcare Center	98,218.00	31,652.00
Rincker Residential	45,906.00	14,794.00
	260,491.00	83,946.00
Salaries reported on this cost report	(98,218.00)	(31,652.00)
Salaries reported by other homes	162,273.00	52,294.00